

STATE OF VERMONT
AGENCY OF HUMAN SERVICES
DIVISION OF RATE SETTING

METHODS, STANDARDS AND PRINCIPLES FOR
ESTABLISHING MEDICAID PAYMENT RATES
FOR LONG-TERM CARE FACILITIES

JULY 1, 1998

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I. INTRODUCTION

- (a) The purpose of this plan is to implement state and federal reimbursement policy with respect to all nursing facilities providing services to Medicaid residents, Long-term care services in swing-bed hospitals, and Intermediate Care Facilities for the Mentally Retarded.
- (b) The methods, standards, and principles of rate setting established herein reflect the objectives for nursing facility reimbursement set out in 33 V.S.A. §901 and balance the competing policy objectives of access, quality, cost containment and administrative feasibility. Rates set under this payment system are consistent with efficiency, economy, and quality of care necessary to provide services in conformity with state and federal laws, regulations, quality and safety standards.
- (c) This plan complies with the requirements of 33 V.S.A. Chapter 9, §1902(a)(13)(A) of the SSA.
- (d) The State has in place a public process which complies with the requirements of Section 1902(a)(13)(A) of the Social Security Act. The Division shall make rules and issue practices and procedures pursuant to the Vermont Administrative Procedures Act, 3 V.S.A. §836 *et seq.* to carry out the provisions of this plan.
- (e) The Division shall, according to this Plan, establish and certify to the Department of Social Welfare for payment per diem rates for providers of long term care services on behalf of residents eligible for assistance under Title XIX of the SSA.

II. ACCOUNTING REQUIREMENTS AND FINANCIAL REPORTING

- (a) All financial and statistical reports shall be prepared on an accrual basis in accordance with Generally Accepted Accounting Principles (GAAP), consistently applied. The Division may prescribe rules and practices and procedures relating to variations in accounting principles, cost allocation, record keeping and retention, and related matters. (See Addendum A §2.)
- (b) Each nursing facility and Intermediate Care Facility for the Mentally Retarded in Vermont shall annually submit a uniform cost report on forms prescribed by the

Division, according to rules and practices and procedures adopted by the Division.. (See Addendum A §3.2)

- (c) The Division will review the cost reports, will perform periodic audits, and will settle the cost reports, as required by its rules, practices and procedures, and 42 C.F.R. §447.253(e). (See Addendum A §3.4-3.5.)

III. DETERMINATION OF ALLOWABLE COSTS FOR NURSING FACILITIES

- (a) In determining the allowability or reasonableness of costs or the treatment of any reimbursement issue, not addressed in this plan, the Division shall apply its own rules and appropriate provisions of the Medicare Provider Reimbursement Manual (HCFA Publication 15). (See Addendum A §4.1.)
- (b) The Division will adopt rules for the transfer of ownership of depreciable assets. In no case shall the change in basis, as applied in the aggregate to facilities which have undergone a change of ownership, be greater than the lesser of the (1) the fair market value of the assets, (2) the acquisition cost of the asset to the buyer, (3) the amount determined by the revaluation of the asset. An asset is revalued by increasing the basis of the asset to the seller by an annual percentage rate, limited to the lower of: one-half the percentage increase in the Consumer Price Index (CPI) for All Urban Consumers (United State City Average) or one-half the percentage change in an appropriate construction cost index as determined by the Division of Rate Setting, which change shall not be greater than one-half of the percentage increase in the Dodge Construction index for the same period. (See Addendum A §4.7.)

IV. CASE-MIX REIMBURSEMENT STANDARDS

- (a) Rates set under this plan are intended to provide incentives to control costs and Medicaid outlays, while promoting access to services and quality of care. This case-mix reimbursement system takes into account the fact that some residents are more costly to care for than others.
- (b) Case-mix rates shall be adjusted based on resident assessments made pursuant to 42 C.F.R. §483.20, according to the resources utilized to care for the residents of each facility. (See Addendum A §5.1.) Case-mix adjustments may be limited to Medicaid residents only. Thus the system requires:
- (1) the assessment of residents on a form prescribed by the Director of the Division of Licensing and Protection,
 - (2) a means to classify residents into groups which are similar in costs, known as 1992 RUGS-III (44 group version); and
 - (3) a weighting system which quantifies the relative costliness of caring for different classes of residents to determine the average case-mix score for each facility. (See Addendum A §7.2)
- (c) Per diem rates shall be prospectively determined for the rate year, based on the allowable operating costs of a facility in a Base Year plus property and related and ancillary costs from the most recently settled cost report. (See Addendum A §7.8.)
- (d) A Base Year shall be a calendar year, January through December. The Director shall determine the frequency of rebasing and shall select the Base Year. However, rebasing for Nursing Care costs shall occur no less frequently than once every three years and for other costs no less frequently than once every four years, unless the Secretary, on the advice of the Director, certifies to the General Assembly that rebasing is unnecessary. (See Addendum A §5.6.)
- (e) In the case-mix system of reimbursement, allowable costs are grouped into cost categories. The accounts to be used for each cost category shall be prescribed by the Director. (See Addendum B §6.) The Base Year costs shall be grouped into the following cost categories: Nursing Care Costs, Resident Care Costs, Indirect Costs, Director of Nursing, Property and Related, and Ancillaries. Nursing Care costs shall be adjusted

quarterly for changes in each facility's case-mix score.
(See Addendum A §9.7.)

(f) The following cost limits shall be applied:

- (1) Nursing Care component - median cost for all facilities plus 15 percent.
- (2) Resident Care component - median cost for all facilities plus 5 percent.
- (3) Indirect component - median cost for all facilities
(See Addendum A §§7.2-7.4)

(g) The Division shall by rule establish a method for determining the appropriated number of resident days to be used in calculating per diem rates and shall prescribe a minimum occupancy level (not lower than 90 percent of the certified beds in each facility) to be used for the purpose of calculating per diem costs and rates, which may be waived by rule for certain types of facilities, including, but not limited to, those with 20 or fewer beds or terminating facilities. (See Addendum A §5.7.)

(h) The Division shall by rule prescribe methods to be used for adjusting costs for projected economic conditions during the rate period. The Division may use inflation factors based on the DRI-NHMB and/or the NECPI or similar indexes. Different inflation factors are used to adjust difference rate components. Subcomponents of each inflation factor are weighted in proportion to the percentage of average actual costs incurred by Vermont facilities for specific subcomponents of the relevant cost components. (See Addendum A §5.8) The indexes that are used for calculating the inflation factors are as follows:

- (1) Nursing Care - wages and salaries portion of DRI-NHMB and employee benefits portion of DRI-NHMB;
- (2) Resident Care - wages and salaries portion of DRI-NHMB, employee benefits portion of DRI-NHMB, food at home portion of the NECPI-U, commercial power, 40 KW demand portion of the NECPI-U, and the NECPI-U (all items);
- (3) Indirect - wages and salaries portion of DRI-NHMB, employee benefits portion of DRI-NHMB, and the NECPI-U (all items);
- (4) Director of Nursing - wages and salaries portion of DRI-NHMB and employee benefits portion of DRI-NHMB;

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- (i) Special rate provisions or exemptions may be adopted by rule for state nursing facilities, and for facilities operating under unique or special circumstances, including but not limited to new facilities, facilities providing special services to populations with distinct characteristics, terminating facilities, facilities in receivership or facilities qualifying for extraordinary financial relief. (See Addendum A §§5.9, 5.10, 9.8, 9.9, and 10.)
- (j) Prospective adjustments may be made to rates set under this plan for certain circumstances, prescribed by rule, which may include, but are not limited to, changes in services, changes in law, facilities in receivership, efficiency measures, changes in interest rates, emergencies and unforeseeable circumstances. (See Addendum A §8.)
- (k) The total per diem rate in effect for any nursing facility shall be the sum of the rates calculated for all components, limited by the caps (median plus a percentage as set out in Addendum A) adjusted in accordance with the Inflation Factors (calculated as described in Addendum A) and all adjustments. These rates may be adjusted periodically, according to rule, for changes in case-mix. (See Addendum A §9.)
- (l) The Division may retroactively revise a rate under certain circumstances, specified by rule, which may include, but are not limited to, finalizing interim rates, responding to an order of the Secretary or a court of competent jurisdiction, or in settlement of an appeal, for terminating facilities or for facilities in receivership, for the recovery of over- or underpayments, or to pass the upper limits test. (See Addendum A §5.2)
- (m) Aggregate payments to nursing facilities pursuant to this plan shall not exceed the limits established for such payment in 42 C.F.R. §447.272, using Medicare principles of reimbursement and, notwithstanding any other provision of this plan, the Division may adopt rules limiting reimbursement to facilities, if the Division determines that this limit is likely to be exceeded. (See Addendum A §5.5.) Neither shall the Medicaid per diem rate paid to any provider exceed that provider's average customary charges to the general public for its nursing facility services. (See Addendum A §5.3.)

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- (n) Additional quality incentive payments may be made to nursing facilities providing a superior quality of care in an efficient and effective manner.

V. PAYMENT FOR OUT-OF-STATE PROVIDERS

- (a) Payment for services, other than Rehabilitation Center services, provided to Vermont Medicaid residents in long-term care facilities in another state shall be at the per diem rate established for Medicaid payment by the appropriate agency in that state. Payment of the per diem rate shall constitute full and final payment, and no retroactive settlements will be made. (See Addendum A §11.1.)
- (b) Payment for Rehabilitation Center services provided in nursing facilities located outside Vermont for the severely disabled, such as head injured or ventilator dependent people, will be made at the lowest of the amount charged or the Medicaid rate, including ancillaries as paid by at least one other state agency in HCFA Region I. (See Addendum A §11.2.)
- (c) Payment for Rehabilitation Center services which have not been authorized by the Medicaid Director or a designee will be made according to Subsection (a).
- (d) Payment for pediatric care in out-of-state facilities requires the prior authorization of the Director of Vermont Health Access.

VI. RATES FOR ICF/MRS

- (a) Intermediate Care Facilities for the Mentally Retarded (ICF/MRs) are paid according to Medicaid principles of reimbursement, pursuant to the *Regulations Governing the Operation of Intermediate Care Facilities for the Mentally Retarded* adopted by the Agency for the Department of Developmental and Mental Health Services. (See Addendum A §12 and Addendum B.)
- (b) ICF/MRs are reimbursed under a retrospective payment system. Interim rates are paid with retroactive adjustments and final settlements after audit of costs. Allowability of costs is determined in accordance with the Provider Reimbursement Manual (HCFA-15) requirements

VII. RATES FOR SWING BEDS

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Payment for swing-bed nursing facility services provided by hospitals, pursuant to §1913(a) of the SSA, shall be made at a rate equal to the average rate per diem during the previous calendar year under the State Plan to nursing facilities located in the State of Vermont. (See Addendum A §13.)

VIII. ADMINISTRATIVE REVIEW AND APPEALS

(a) As required by 42 C.F.R. 447.253(c), the Division shall by rule prescribe procedures for prompt administrative review and appeals of cost report findings and such other matters as the Division finds appropriate, in addition to such other appeals as are prescribed by Vermont statute at 33 V.S.A. §909. These procedures shall offer individual providers an opportunity to submit additional evidence. (See Addendum A §15.)

(b) The Division or the Agency may agree to settle all such reviews and appeals or litigation arising from the work of the Division on such reasonable terms as the Division or Agency may deem appropriate to the circumstances of the case. (See Addendum A §15.8.)

IX. DEFINITIONS AND TERMS

For the purposes of this plan the following definitions and terms are used:

Accrual Basis of Accounting: an accounting system in which revenues are reported in the period in which they are earned, regardless of when they are collected, and expenses are reported in the period in which they are incurred, regardless of when they are paid.

Agency: the Agency of Human Services.

AICPA: American Institute of Certified Public Accountants.

Allowable Costs or Expenses: costs or expenses that are recognized as reasonable and related to resident care in accordance with this plan and the Division's rules.

Ancillary Services: therapy services and therapy supplies, including oxygen, whether or not separate charges are customarily made. Other medical items or services identifiable to a specific resident furnished at the

direction of a physician and for which charges are customarily made in addition to the per diem charge.

Base Year: a calendar year for which the allowable costs are the basis for the case-mix prospective per diem rate.

Case-Mix Weight: a relative evaluation of the nursing resources used in the care of a given class of residents.

Cost Report: a report prepared by a provider on forms prescribed by the Division.

Director: the Director, Division of Rate Setting, Agency of Human Services.

Division: the Division of Rate Setting, Agency of Human Services.

DRI: Data Resources Institute Incorporated's *Health Care Costs*, as published by McGraw-Hill, including national forecasts of hospital, nursing home, and home health agency market baskets and regional forecasts of CPI (All Urban) for food and commercial power and CPIU-All Items.

Facility or nursing facility: a nursing home facility licensed and certified for participation in the Medicaid Program by the State of Vermont.

FASB: Financial Accounting Standards Board.

Generally Accepted Accounting Principles (GAAP): those accounting principles with substantial authoritative support. In order of authority the following documents are considered GAAP: (1) FASB Standards and Interpretations, (2) APB Opinions and Interpretations, (3) CAP Accounting Research Bulletins, (4) AICPA Statements of Position, (5) AICPA Industry Accounting and Auditing Guides, (6) FASB Technical Bulletins, (7) FASB Concepts Statements, (8) AICPA Issues Papers and Practice Bulletins, and other pronouncements of the AICPA or FASB.

Generally Accepted Auditing Standards (GAAS): the auditing standards that are most widely recognized in the public accounting profession.

Health Care Financing Administration (HCFA): Agency within the U.S. Department of Health and Human Services (HHS) responsible for developing and implementing policies governing the Medicare and Medicaid programs.